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ABSTRACT

A study examined the ways a group of people experiencing poverty, poor housing, and stress assessed the impact of these factors on their health through participating in a course called "Health Issues in the Community." It involved people from a range of socioeconomically excluded areas and groups throughout Scotland in identifying and investigating local concerns about health issues that affect them. The assumption underpinning the course was that social action in the health field is fundamental to control of our lives. At the end of the course, participants investigated and wrote about an important health issue in their community. One issue was poverty's impact in relation to women and families. Women took primary responsibility for child care and domestic labor and for their family's health; this inevitably led to stress. They put their own health last. Another issue was poverty's impact on housing and health. Many socioeconomically-excluded communities identified poor housing as a major health issue. Isolation was another factor that led to stress and depression for residents of high-rise flats, a common feature of socially excluded communities. Course participants demonstrated community development as one way to end the spiral of despair regarding poor housing and ill health. Contesting official definitions of health was a key issue in working with communities on their own health issues, with a number of implications. (Contains 23 references.) (YLB)

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Health concerns in communities and the wider benefits of learning. Perspectives from practice in Scotland.

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Introduction

A great deal of research has shown how poor health in the UK is linked to inequality, poverty and social class both in terms of the diseases people die from and the illness they suffer (Acheson, 1998; Annandale. and Hunt, 2000; Benzeval, et al, 1995; Wilkinson, 1996). For example, a baby whose father is an unskilled manual worker is one and a half times more likely to die before the age of one as the baby of a manager or professional employee. In addition the poorest children are twice as likely to die from a respiratory illness and more than four times as likely to be killed in a road traffic accident as those from social class I (Leon et al, 1992). As Graham, (2000: 90) puts it '*Social class is written on the body: it is inscribed in our experiences of health and our chances of premature death*'. Similarly people's experience of the place where they live is also fundamental to the quality and meaning of their day-to-day life and health. These include social relations with people, the physical fabrics of the locality and the local geographies of services and facilities. Research is beginning to demonstrate that, in combination, features of place can be either sustaining or undermining of psychosocial well being and health (Gattrell et al, 2000: 166).

This paper puts this large-scale research into a local context by examining the ways that a group of people experiencing poverty, poor housing, and stress, have assessed the impact of these factors on their health through participating in a course called 'Health Issues in the Community'. The course has involved people from a range of socio-economically excluded areas and groups throughout Scotland in identifying and investigating local concerns about the health issues that effect them. The course has provided opportunities for people to express their own views, and to question everyday assumptions, explanations and definitions, particularly where they differ from their own experience. It draws on people's lived experience of individual and community health problems to build a curriculum based on the issues that they believe are important to them and their communities. This has involved tutors developing a meaningful relationship with each group so that the design of the programme takes account of the societal influences that impact on them. The paper also considers the participants' views of the role that learning can play in mitigating the worst health effects of their poor socio-economic and psychosocial environments.

The assumption underpinning the course is that social action in the health field is about educating ourselves to see that the control of our health is fundamental to the control of our lives. While individually focused medicine does not consider the social origins of many illnesses, the community health movement has attempted to do so. Rather than blame our-selves for our ill health, the focus is on the damaging social experiences that produce ill health and, furthermore, there is an understanding that remedial action needs to be social. This view of health focuses on the socio-economic risk conditions such as

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poverty, unemployment, pollution, poor housing and power imbalances that cause ill-health. It also emphasises that '*people's experiences of health are more about the quality of their emotional and social situation than about their experience of disease or disability*' (Labonte, 1997: 9). The perspective taken by the course is that an important way that inequalities in health can be tackled is to find ways of strengthening individuals and communities so that they can join together for mutual support. As Whitehead points out, '*research shows that by people joining together you can strengthen the whole community's defence against health hazards*' (Whitehead, 1995: 25).

At the end of each course participants investigate and write about a health issue in their community that they believe is important. To date sixty-four people have completed these essays and a selection of their writings has been published in three books edited by Jane Jones (Jones, 1999a & b, 2001). I will be drawing on these published writings to illustrate this paper by using the words of the participants to demonstrate the impact that these health issues had on their lived experience and the action they took to bring about change. I will do this by focusing on two aspects of the impact of poverty on the health of the participants in the courses firstly, in relation to women and families and then in relation to housing factors. The names of the students are pseudonyms.

Women, families and poverty

A gendered division of labour in which women take primary responsibility for childcare and domestic labour sustains family life in Britain. These combined responsibilities make for long working days that are structured by other people's needs (Graham, 1994: 116). Students on the course were all too aware of this. As one pointed out:

> A woman is the prime carer; money manager and financial wizard; purchaser of all food, clothes and household necessities. Try to imagine how difficult and impossible it is for her to manage [on a low income]. This is not a short-term problem but is the reality day after day. Coping with this daily is extremely detrimental to a woman's mental health (Anne, in Jones, 1999b: 18).

Another suggested:

> Poverty breeds ill health. Whether food is nutritious is not the main issue, just being able to buy food of any description is the first priority. Poverty is powerlessness. There is no choice as to where you live. Poverty is not being able to keep a warm comfortable home, thereby being unable to combat dampness and condensation. Poverty is defeat. The feelings of hopelessness and worthlessness can lead to the downward spiral of drug taking and alcoholism, which are ways of escaping from miserable surroundings and the awful day to day living and isolation (Fiona, in Jones, 2001: 29).

This raises an important issue about the development of social agency. The first step in developing a more active approach is that people need to recognise that they are strategic

actors who make choices in response to their oppressive social situations. Graham, (1994: 119) points out that:

> Parents bringing up children on low incomes spend more of the little they have on collective necessities, like food and fuel, than do better-off households. It is a strategy for survival that leaves a mother constantly aware of her family's poverty: of what they have not got and what they cannot do. It is a lifestyle of enforced exclusion from the communities to which they belong.

Students' on the course illustrate this:

> Stress is an inevitable part of life for those living on the breadline. The constant worry about making ends meet, about looking after your family and their needs. For people in poverty, the stress of being unable to cope can be a killer (Sandra, in Jones, 1999b: 7).

> When you live in poverty you are forced to make choices between items which others take for granted such as, heating, lighting or a nutritionally balanced meal. Managing on a low income is a constant worry because you cannot afford to take part in anything social like Gala days, school fetes, day trips to the beach or even school uniforms for the children (Emma, in Jones, 2001: 24).

Women take responsibility for their family's health and this inevitably leads to stress especially for those living in poverty. As one minority ethnic student commented:

> In my community it is a responsibility of the family to look after the elders. Husbands have long hours of work from 7am to 9pm, and they can't share household responsibilities. Women do not have time for themselves, looking after young children, providing help to the elderly, looking after husbands coming in late at night. The one woman in the house performs all these jobs (Aisha, in Jones, 2001: 19).

Another student who lived in a socio-economically excluded community suggested:

> To wander round a glossy supermarket with very little money in your purse – it's little wonder this leads to depression, a sense of never coping and always having to make a choice between heating your home or buying a wholesome varied diet for your family (Maggie, in Jones, 1999b: 25).

The way that women do put their own health last, giving their main priority to looking after their children or family, became more and more apparent as the course tutors worked with different groups of women. An example of this was one student's definition of what she meant by health.

> If you're healthy enough to get up in the morning to do what you've got to do without having to worry about being exhausted or breaking down by dinner time.

> That's my idea of health. I've got to be healthy for my family (Beth, in Jones, 1999a: 16).

Here women reflect societal assumptions about their role as carers for their children where their core work is focused around maintaining family life. For women to prioritise their own needs is to challenge both the cultural assumptions about women's place in society and the patriarchal division of labour (see Van Every, 1996).

Housing and Health

Statistically owner-occupiers have lower risks of death and better health than people who rent their homes (Macintyre et al, 2000). Research suggests that socio-economic status, the physical and social features of the home and the area and psychological characteristics such as self-esteem interact to produce these outcomes (*ibid.* 138). Poor housing is one of the major health issues identified by many socio-economically-excluded communities. As one student put it:

> In my community due to poor housing design and inadequate heating systems families are forced to live with dampness. If they did heat their houses properly they probably would not be able to afford to eat, and are therefore forced to live with dampness in their homes (Frank, in Jones, 1999b: 8).

Isolation is another factor that leads to stress and depression for those living in the high-rise flats that are a common feature of socially excluded communities. *Isolation is a major problem in the flats as you can go for days without seeing anybody* (Cathy, in Jones, 1999b: 9). Animosity between neighbours is also a problem when people are living, quite literally, on top of each other. This is often combined with overcrowding especially for those with large or extended families.

Participants in the course demonstrated that one way of ending the spiral of despair regarding poor housing and ill health is through community development. This means that rather than seeing dampness and the noise pollution caused by poor housing as an individual trouble, that must be solved by an individual taking action themselves, the reasons behind the problem are examined. As one student put it:

> The way forward is through the community development process where individuals come together and tackle the problem as a public issue rather than a private one. Their strategy then becomes forcing the housing department to address the problem of poor housing and developing effective procedures in dealing with noisy neighbours (Alan, in Jones, 1999b: 35).

The process of community development can be frustrating and it takes a long time. However, it is worthwhile as by developing strategies for tackling the problems and taking their issues to the wider community a group can grow in confidence and eventually will be able to take well thought out solutions to policy makers. One group involved in the course eventually gained better insulation, cladding, soundproofing and

heating through a long campaign of local and wider action. As one member of the group put it:

> This had an instant effect on improving people's health both directly and indirectly by reducing people's stress and anxiety levels. Your home should be a place where you can relax, unwind and escape from the outside world (Jimmy, in Jones, 1999b: 35).

Contesting official definitions of health

It appears that the medical dominance over the definition and analysis of health and illness is still disproportionately influential in health policy and practice (see Graham, 2000; Purdy and Banks, 1999; Townsend et al 1992). It is still a struggle for policy makers to give priority to the political and social determinants of health and to make the connections between the psychosocial effects of lack of control over the social and material conditions of people's lives and poor health. Moreover, there is a pervasive assumption that it is people's individual life styles that need to be changed in order to improve health rather than their social and material conditions. Contesting these official definitions of health was therefore a key issue in working with communities on their own health issues. This had a number of implications that are explored below.

Just as the assumption that pervades education is that it is not the fault of the schools if they fail to educate disadvantaged children but is the fault of their mothers (see Luttrell, 1997) so this same assumption pervades views about where responsibility lies for maintaining children's health. An important aspect of the course, therefore, was to help women to prioritise their own health needs and to analyse the structural issues that led to their ill health and that of their families. In one area a survey was undertaken by a group of women of the health provision that was needed in their community. The information from the study led the project to create some protected time for women, with childcare, so that they might have the space to think about their own health. A number of groups were set up that created an opportunity for women to reappraise their role and begin to find time for themselves and be able to take action to change their lives (see Jones, 1999a: 17).

One aspect of women's tendency to see themselves as individually responsible is that they can easily become isolated especially when they are on their own with their children. One student remembered how she felt when she first found herself with total responsibility for her children with no friends or family nearby to help. *'I felt alone, isolated and scared. The fear was the worst, especially at night, after the children had gone to bed, as I sat alone in the quiet darkness worrying about all the things that could go wrong'* (Diane, in Jones, 2001: 36).

Another woman described her feelings of inadequacy when she was a young mother trying to raise three children on a very low income. She also showed how getting together with others had helped her. She said:

> It was a struggle to pay the rent, feed them and try to clothe them. It would have been all too easy to say 'to hell with it' and to escape into oblivion with drink or drugs. I knew the feelings of helplessness, but also of guilt. I thought it was all my fault. At the time I didn't realise how ill I was although I would never have gone to a doctor any way, as I felt so ashamed and thought that I would be blamed and lectured to. [Then I got to meet some other people through the toddlers group and I realised I wasn't alone]. Coming together made me feel part of a whole. It helped end my isolation and hopelessness (Elsie, in Jones, 2001: 30).

Once people feel that they are able to take action then much can change. For example, one student was fed up with the media blaming people for their own poverty and got together with other people to see what she could do. She and the others talked to community education staff and they helped them get organised to sort out what were the big issues and how to work from there. She explained:

> Healthy diet was a big issue and it was the priority. The shopping centre was the only place in our town that you could get fresh fruit and vegetables but the prices were way above most people's budgets. We decided to take action first of all about telling people what were healthy foods. Then we went to our local farmer to buy our fruit and vegetables so that we could sell them cheaper, only adding on the cost of petrol. The group sent out leaflets giving information on where to go to buy cheaper fruit and vegetables, the response was staggering. Everyone knows what a healthy diet is but they just can't afford it (Hetty, in Jones, 2001: 33).

A challenge for people is to see the potential that effective social action has in de-privatising their pain. By making public poor people's experience of the burdens they carry both publicly and privately in a classed system of domination it becomes possible to see their problems as the direct result of the countless contradictions inherent in their social position. One aspect of this is challenging the stigma associated with mental health and the medical solutions that are offered. Participants in the course described their worries about going to the doctor with their symptoms and their fears about the impact this will have on their children. For example, one student said: '*It is really frightening to say what you feel. You think, if I tell them that, the bairns* [children] *will get taken away. You're frightened of being labelled a bad mother*' (Joan, in Jones, 1999a: 91).

Another participant who lived in an overcrowded flat in a tenement building with anti-social neighbours described how these pressures led to stress and then to depression. She said:

> It got to the stage that I decided to go to the doctor. I explained my problem to him, then the pen comes out and the miracle cure in the doctor's eyes is to prescribe anti-depressants, that's what I was sent away with. I got outside the surgery and thought to myself no way am I going to rely on pills to help me with my problem. I thought I'd like to tackle this on my own so I would get up early in the morning and walk practically everywhere all day long (Kate, in Jones, 1999b: 9).

Moving from an individual solution, however, to one that comes from collective action is the next step but this usually needs the intervention of 'skilled helpers' (see Brookfield, 2000). One way in which the 'Health Issues in the Community' course provides such help is to show how apparently private troubles are actually public issues (Mills, 1959). An important aspect of this has been to look at the issue of mental health. For example, two students commented on the ways in which their own understanding had changed:

> I had been on tranquillisers but I felt so ashamed about it that I hid it from everyone. Then this young woman spoke up about her experience in the discussion group and I realised that lots of women had had the same feelings. You have to learn that it isn't your fault but you need people to talk to about it first (Laura, in Jones, 1999a: 130).

> I'm involved with the Stress Centre now that got set up really because a group of us started to think about what would have helped us more than just getting a prescription. We decided that it was somewhere to go to get a bit of support and someone to talk to so we talked to a lot of different people and eventually the Centre was set up. Working there has done a lot for my self-confidence and I know that we can help people. It takes time but it can be done (Norah, in Jones, 1999a: 133).

Working with a community to increase self-determination and take control over its collective resources is an important task for educators. Building organisations, taking action to redistribute resources, ensuring that community voices are heard all have direct health benefits. This is because lack of control over one's own destiny promotes a susceptibility to ill health for people who live in difficult situations where they do not have adequate resources or supports in their day-to-day lives (see Annandale and Hunt, 2000). Clearly the people who participated in this course have involved themselves in action that has enabled them to move from a position of powerlessness to one of empowerment in relation to the issues about health that are important to them.

Conclusion

A wide range of research that has examined the areas of socio-economic status, occupational health and stress has shown consistently that powerlessness, or lack of control over destiny, is a high risk factor for disease. It demonstrates that being poor, low in the hierarchy, without control and living in chronic hardship increases susceptibility to higher morbidity and mortality rates (Wallerstein, 1992: 199). Learning that contributes to empowerment can, on the other hand, reduce these risk factors by enabling participants to be decision makers, '*developing mutual identification and transforming perceptions of self blame through an analysis of the social context of problems*' (*ibid.* 204).

The personal and social damage inflicted by inequality, social exclusion and restricted opportunity is now recognised by government in the UK. An important component of social inclusion is learning which should represent a resource for people to help them identify inequalities, probe their origins and begin to challenge them, using skills,

information and knowledge in order to achieve and stimulate change. Through learning, competing values can be reviewed, their relevance for society can be assessed, and newly emerging values can be transmitted (see Fryer, 1997).

Clearly, whilst learning alone cannot abolish inequality and social divisions it can make a real contribution to combating them, not least by tackling the ways in which social exclusion is reinforced through the very processes and outcomes of education and health. If people can be helped to challenge deficit views of the health of their homes and communities then a small step has been taken in enabling their voices to be heard. Enabling communities to name and frame their health problems for themselves and build their own really useful knowledge thus becomes an important benefit of learning. Shifting the emphasis away from disease and ill health and a focus on individual's lifestyles onto the ways in which well-being can flourish has been an important outcome of this course. A community development approach to health enables community groups to establish for themselves what their health issues are and provides a means through which they can explore the root causes of their problems. The impact of such work can be seen in three broad areas. Firstly, an increase in agency and thus better health through increased self-esteem, confidence and empowerment; secondly, more local control over decision-making thus improving delivery of health services to meet locally identified needs. Finally a holistic approach to health can contribute towards the creation of an alternative framework through which to understand health issues from a broad-based, sustainable perspective.

The course, 'Health Issues in the Community', has provided opportunities for people to express their own views, and to question everyday assumptions, explanations and definitions, particularly where they differed from their own experience. In a field where official definitions can exert a powerful influence over the content of communication the project has sought to help local people focus on health information that is meaningful to them because it comes from their own experience. By taking action, for example over housing or high food costs or the stigmatisation involved in mental health issues, local people assume control and create, rather than receive, meaningful knowledge. Learning together collectively and then taking action based on what has been learnt is an empowering process as people start to take back control over their own destiny and directly improve their own health and that of their communities.

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